MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, April 13, 2001
9:02 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
AUTRY O.V. DeBUSK
GLENN M. HACKBARTH
FLOYD D. LOOP, M.D.
ALAN R. NELSON, M.D.
JANET G. NEWPORT
CAROL RAPHAEL
ROBERT D. REISCHAUER, Ph.D.
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM
Payment for care in skilled nursing facilities in Alaska and Hawaii (Al Dobson, senior vice president, The Lewin Group)

AFTERNOON SESSION [12:09]

DR. WILENSKY: If we can get started?

DR. ROSS: I guess this is all ashore that's going ashore. As we mentioned in executive session yesterday, we had asked the Lewin Group to do an analysis of Medicare payment rates to skilled nursing facilities in Alaska and Hawaii in preparation for a report that the Commission is mandated to submit next month. I'd like to welcome Al Dobson, senior vice president; Joan DaVanzo, vice president; and Lane Koenig, senior manager. They're going to present and we anticipate sending a fairly brief letter/report along with their contract report to the Congress to meet the deadline in mid-May.

Thank you.

DR. DOBSON: I understand we don't have overheads. I'll just tell you what page I'm on and we'll go through these slides.

I'm very pleased to be here. I looked at my notes this morning. The last time I was before the Commission was February 2nd, 1984 -- it's been a while. At that time I presented the outlines and architecture of the then brand new PPS. You folks have taken very good care of the baby over these years. It's probably one of the most viable, current, strongest, best payment systems in the world, and I'm right pleased to see you took very good care of it.

Page 2. In terms of issues, the 1999 BBRA asked MedPAC to

take a look and see if there were some unique circumstances for SNFs in Alaska and Hawaii. The basic question was, should there a COLA or an additional payment made for higher cost in the non-labor portion of the payment amount?

As we turn to page 3, the current payment system, as with most systems, has a labor and non-labor portion. The labor portion is about 78 percent, the non-labor portion is 22 percent. The question before you is, should that 22 percent be adjusted for something like a cost-of-living adjustment in the states of Alaska and Hawaii?

The system is currently in a three-year phase-in which ends roughly this July, and at the end of that phase-in there will be no COLA adjustments for the skilled nursing facilities in Alaska and Hawaii.

Now on the next page we take a look at what a non-labor factor is, page 4. The drift of it is, in Alaska and Hawaii the argument is that utilities, other products, telephone services, non-labor intensive services, whatever that is, and capital related expenses are more costly. You can kind of imagine why that might be the case in both situations, Alaska and Hawaii.

Indeed, when we built the DRG system we did put an adjustment factor, a COLA adjustment in for our PPS at the time on the non-labor side, something on the order of 25 percent relative to Washington, D.C. So at that time we made the judgment, and I remember making it, that we basically said, these places are pretty extreme, let's put an adjustment COLA on the non-labor portion.

Now I'm going to summarize a series of tables. Unfortunately, there's no one knockout table that I could present to you today that basically says to you as commissioners, this is the answer that you're looking for. I'm going to provide you a series of tables that kind of go from hither to yon which suggest, by and large, that costs are higher in Alaska and Hawaii, but you're going to have to make some very careful deliberations on whether you think they're high enough to merit a COLA in the non-labor portion of the SNF prospective payment.

Turning to the first table, page 5, here we took the 1998 Medicare cost report information on cost per case basis and we asked ourselves the question, how do the inpatient hospital costs rank? What we find is, Alaska number one, Hawaii number two, Maryland a fairly distant number three, then Maine, and D.C.

Now the problem with this slide is several-fold. First, it's inpatient acute care, not nursing homes. Although in Alaska, most of the nursing homes are hospital-based. Secondly, we get all mixed up here in prices and quantities because this is a cost per case. It has labor, it has non-labor in it, and it also has various volumes of labor even though we do adjust, as you can see in the footnote, for case mix, wages, teaching, and disproportionate share.

That said, it's still interesting to note that on this measure at least -- this is the cleanest one we have -- that Alaska ranks number one and Hawaii number two.

Now the next thing we looked at, we asked ourselves the question, what about the GPCI, which you folks have dealt with

over the years on the Medicare fee schedule? On page 6 we note that if you take a look at the GPCI which accounts for rent, supplies, equipment, the kinds of things that are in non-labor adjustments, we see now that Alaska and Hawaii are no longer number one. Indeed, number seven for Hawaii and number 17 for Alaska. Now you might say this is a little bit of beside the point, but it had very much the feel of the kinds of things we were looking for.

Now on the next slide we do cost-of-living indices, and now things start to get truly messy in that when we went on the Internet and we did our research we couldn't find cost of living. In fact, for instance, some of the indices have Alaska in them and some of them don't.

So we provide you two indices on page 7. You will note that for Alaska, which did not have Hawaii in that particular index -- that would be the Chamber of Commerce I guess -- that Kodiak, Anchorage, and Fairbanks on these particular measures cost of living, were number two, three, and eighth in the nation respectively at 36 percent higher on food. Hawaii, on the other hand, in another index was 51 percent higher on food.

As you move down to utilities, Kodiak again is ranked number one in the country at 200 percent higher on utilities, whereas Hawaii was 136 percent higher than the U.S. average. Miscellaneous goods and services, Kodiak is 26 percent higher where Hawaii was essentially the U.S. average. And for health care, Fairbanks now was number two in the country at 68 percent higher, and then in Honolulu it was 19.2 percent higher.

DR. ROWE: Could I ask you a question about Kodiak? That's interesting, but my understanding is that Kodiak is an island, it's out there just in the southern part of the beginning of the Aleutian chain. It's got a very small population. Not that this state has a large population. But you could have found maybe Unalaska Island, which is I think the furthest out and last inhabited one on the chain, and that may have been even higher, if they had data for it.

What does that tell us? Why is it worth including some small, little island like that? I can see Fairbanks, although it's so far north --

DR. DOBSON: Let's take Anchorage. Anchorage is number three, right behind Kodiak -- on the miscellaneous goods and service, Anchorage is number three behind Kodiak at two. We looked at the map, as you have in your head, and we too came to the conclusion that Alaska is very sparsely populated with cities all over the place, so to speak, with no roads -- you've been to Alaska -- no roads, et cetera.

We thought that Kodiak, Anchorage, and Fairbanks -- we picked the ones that were highest, Anchorage being an anchor, if you will, excuse the bad pun, and it's right behind Kodiak. So I think that the central tenency here is pretty well spoken for in that Anchorage and Kodiak were roughly the same order of magnitude.

MR. KOENIG: We tried mapping actually, the ones that we could in Alaska, the SNFs on a map, and we were able to map one to Kodiak. So we're talking about one in Kodiak. So from what

we could tell there's at least one.

DR. ROWE: There is a SNF there?

DR. DOBSON: Yes. Now on the next page, page 8, we'll look at some composite measures. In Honolulu, Hawaii, it's the fifth most expensive city to live in. This Rumsheimer International Index, it had a 150 items in 10 categories. Here we again have Kodiak, Fairbanks, and Anchorage at fourth, fifth, and sixth in another index, the Chamber of Commerce.

Now things get a little more interesting, and a take-home point for you today is that when you look at least these two indices what you see is that California cities, New York, Manhattan, and Boston, lie above Honolulu. And we look at the Chamber of Commerce index -- not on your slide but in our report -- again, Manhattan, a California city, L.A., Long Beach, and Boston lie above Kodiak. So what we have now on this measure is, you have to ask yourself the question, why Hawaii and Alaska when you have New York, Boston, and California cities that are higher on at least this particular index?

Now we have some anecdotal information. We called folks in the state and we said, what's going on in your state vis-a-vis prices? You can imagine the sorts of things we heard. But we learned about dry ice and overnight stays and bush pilots and all kinds of cool things actually. But the point of it is that freight and transportation of goods to offshore states -- Alaska is a little bit of a mixture, but any rate non-mainland -- are more expensive. Particularly when you move away from Anchorage and you have to get somewhere, generally you don't drive it, you

fly it. And therein lies some problems with expenses.

We also heard the cost of repair and maintenance is high because they bring folks in from Seattle or from Anchorage to fix stuff up for them. That costs money. The unavailability of required goods and services in a local market means you have to bring it in. Very much like Puerto Rico in that sense. I just happen to know a little bit about Puerto Rico as well.

Finally, one that was most compelling but we left off your list, so you can add it back on, if you would for us, is the cost of recruitment and maintaining a workforce. Imagine being in Kodiak trying to recruit somebody. You've got to go to Anchorage at best, maybe to Seattle, to find people that you're going to recruit. And then you've got to convince them to come live at the end of the road which is probably going to take some special considerations.

It's anecdotal, but it does seem, I believe, somewhat interesting to note the kinds of things that people that run the institutions both in Hawaii and Alaska pointed out to us.

Now what are you folks to make of this? The first thing you could do is say, this is really compelling stuff. The inpatient hospital looked pretty solid, one and two. Let's recommend to Congress we go along, follow the COLA that's already in PPS, seems good to us.

Then you could say, gee, you got California, you got New York, you got Boston on some of these other indices and they're very much higher than Alaska and Hawaii. Glenn knows that well, doesn't he, now?

Then you could say, we don't have enough information. Maybe the department ought to look a little more carefully.

What might they look at? They might adjust the very first index we talked about, the inpatient hospital care to get rid of those quantities. For instance, you might divide through by length of stay, you might divide through by FTEs per bed or some such thing to try to get more of a pure price measure and see if that looks right. You might go in and get the per diem SNF amounts that were used to calculate the PPS. MedPAC doesn't have them; presumably HCFA does, although they're not easily accessible we understand.

You might look at that and ask the question, after you take a look at per diems and you rank them, Alaska, Hawaii, where do they fall in the rest of the country? You might match up costs and you might say, if they're making money hand over fist -- which I'm not saying they are or they aren't -- then you say, what's an adjustment for? On the other hand, if there's a big discrepancy and they're very highly ranked on SNF per diems, which is what SNFs are paid on, then you might argue, maybe this thing is legitimate.

At any rate, those are the options as we see them, and that's my presentation. Did I make 10 minutes, Gail?

DR. WILENSKY: Thank you. It was terrific. It was interesting and a very focused presentation.

Because I know we are in danger of losing two commissioners in the next 10 or 15 minutes I'm going to make a proposal for people to think about with regard to these options and then just

open it up to discussion either on the facts that were presented or on the options.

I'm going to recommend, in order to try to focus the discussion but obviously you're free to make any alternative recommendations you'd like, is that we combine two of recommendations. First that we have the Secretary collect additional information to evaluate these differences, whether the differences are justified. I think some of the ideas that you just raised are very interesting ones and ought to be included in a discussion to make sure there's flavor. I think that's very valuable.

Then to also recommend that in the interim, while this information is collected, that the COLAs continue, on the grounds that they're --

DR. DOBSON: Strictly speaking, Gail, the COLAs phase out as of July of this year because the prospective payment system on labor part does not have the COLAs in them. The non-federal portion does have COLAs, but that will be phased out this July roughly speaking. It was a three-year phase-in.

DR. WILENSKY: I guess my inclination had been to put it back in. To basically have it in, see whether or not it is justified. I do believe there's enough anecdotal evidence to suggest that it may well be, but when that study is done, then to assess whether or not it should continue. So it would taking the first diamond and the third diamond and putting it together.

DR. ROSS: Could you just clarify on the third diamond whether looking just at SNFs in Alaska and Hawaii, or for all

SNFs? Because if you get into the all SNFs you start to raise the issue of --

DR. WILENSKY: I had meant only this -- we have already made a very strong recommendation about our views of reimbursement to SNFs using the RUG classification. Basically, stop fiddling around and try and find something else. So it seems to me we have made a very strong statement about what we think about the general reimbursement issue. I would regard this as specific to Alaska and Hawaii.

So I'm opening it up as a point of departure, but it strikes me that we definitely need to get some better information, and in the interim to keep the payments.

DR. ROWE: Can I ask whether or not other remote areas that come under the jurisdiction of the United States like Guam, the U.S. Virgin Islands, Puerto Rico, or other places, are we going to hear from them next week? In other words, are there other remote areas where there are Medicare beneficiaries in SNFs that we are going to hear from?

DR. ROSS: We hear pretty regularly from Puerto Rico just trying to get the standardized rate up to the mainland rate, much less with a COLA.

DR. WILENSKY: But it's very different because the tax relationships are so different in the other areas.

DR. ROWE: What about those other ones?

DR. WILENSKY: I assume they also are going to have the same issues with regard to their taxes.

DR. DOBSON: It turns out I've studied the GPCI for Puerto

Rico and very much the same kind of arguments are made, transportation, et cetera. But I think the tax relationship is real important. And the real argument there is the basic standardized payment amount, as was said.

DR. ROWE: With respect to Guam and the U.S. Virgin Islands, do we know anything?

DR. DOBSON: As I recall Guam and the Virgin Islands, on PPS at least, get the standard mainland rate, don't they, Joe?

DR. NEWHOUSE: Yes. I couldn't remember either.

DR. DOBSON: I think they do. You have to check that. But as I recall when I did Puerto Rico, one of the things that folks continued to say is, how come the other guys get the average and we get our lower than average, kind of argument.

DR. WILENSKY: Whatever, they're going to be pretty small amounts of absolute dollars compared to Alaska and Hawaii.

DR. DOBSON: Yes. One thing I didn't say in my presentation is that the balance seems to sway a little bit towards Alaska. The feeling is that Alaska is a little stronger case than Hawaii.

DR. WILENSKY: I agree with that, but I feel a little uneasy about making the distinction when it hasn't been made before and when we're saying, we need to have more information so we know whether this is justified or not. So I would not be surprised at the end of the day if a study indicates it is either legitimate in one case, or certainly more supported in one case and in some question in another. I would personally feel more comfortable to make a distinction that does not now exist after the data rather than before. But again, I'm open to that.

MR. HACKBARTH: I support that recommendation, but just one question, Gail. What sort of information would be used for the study? What sort of data can we --

DR. WILENSKY: I actually liked what Al just --

DR. DOBSON: I threw out two ideas. One is we can take the existing inpatient cost per case, adjusted for length of stay and adjusted for full-time equivalents, to get rid of the quantity side, to make it a more pure price issue. And the second was, why don't we go to the source, the way HCFA calculated the data, pull out those per diems, and take a careful look at them?

DR. REISCHAUER: Isn't that data contaminated by the fact that we're paying them more? Didn't you say that there was an adjustment --

DR. DOBSON: I was going to look at -- these are the cost per case. Now you might argue because they got paid more, they get more.

DR. REISCHAUER: If you don't get paid for what you're doing, you stop doing it. So it has to, over time contaminate it.

DR. DOBSON: You may be right, the cost structure is a function of their income. But we made the judgment in '82 that their costs were higher then as well, by about 25 percent, and apparently those numbers haven't changed all that much.

DR. REISCHAUER: It won't because you give them 25 percent more.

DR. DOBSON: We've probably maintained the differential. Maybe we've maintained the differential they had when we started,

which would be a little less --

DR. REISCHAUER: In a funny way, I think the right thing to do is to look at the production of other service products besides health and compare them, because what you do is so contaminated by how much you pay.

DR. DOBSON: What you find then -- I didn't mention this, but in rural Alaska, construction cost, et cetera, is like twice in Anchorage. It's amazing what's going on.

DR. REISCHAUER: You could end up with bigger numbers.

DR. DOBSON: That's exactly right.

MR. PETTENGILL: Remember that the COLA in the inpatient PPS applies only to 29.9 percent, 28.9 percent, so you're not going to contaminate spending too much.

DR. WILENSKY: Yes. I visited a nursing home above the Arctic Circle when I was at HCFA. I was impressed at some of the difficulties of getting to this, with a census of five, a nursing home in Kotzebue, Alaska. It probably makes me slightly more sensitive to some of the issues, especially in terms of relying on the bush pilots to get people around because there are no roads, and the difficulties of moving both people and products out to where these sites are around Homer and Port Arthur.

Are we ready to take a vote of combining? We'll start with one and three unless someone wants to have a proposal, of collecting information but maintaining the special payments.

All in favor of voting yes?

In favor of voting no?

All those who want to have a not vote recorded?

Thank you. We appreciate it.

DR. DOBSON: Thank you.

DR. ROWE: Since we mentioned Alaska I'm going to take one second and give you a very quick, recent Aetna Alaska story. We have a heroine in our company. I want to tell you about this since it's exciting.

We have the state of Alaska employees as one of our clients, and one of them was on the phone with a claims person from Aetna in Seattle trying to handle a claim problem that she had when the earthquake hit Seattle. And the person from Aetna took the phone, got under her desk, and resolved, adjudicated the claim with the Alaska employee. The guy who sold the case called me and said, Dr. Rowe, we're going to have that case forever. Those people will never go to another insurance company.

DR. WILENSKY: Thank you, commissioners. Thank you, Al and your colleagues. I will be in touch with the commissioners whose appointments are up. Again, thank you very much for all of your participation and help.

[Whereupon, at 12:31 p.m., the meeting was adjourned.]